STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/08/2011			
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH GRANT STREET LEBANON, IN46052				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE	
F0000 F0000	This visit was for State Licensure. Survey dates: A Facility number Provider number AIM number: 1 Survey team: Rita Mullen, RN Janet Stanton, R Michelle Hostet Census bed type SNF/NF: 124 Total: 124 Census payor ty Medicare: 16 Medicaid: 73 Other: 35 Total: 124 Sample: 24 These deficience	or a Recertification and april 4, 5, 6, 7, and 8, 2011 1 000468 1 155378 1 TC N er, RN	F0000	CROSS-REFERENCED TO THE APPROP		DATE	
	Quality review of 2011 by Bev Fa	completed on April 14, ulkner, RN					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Facility ID: 000468

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155378	A. BUILI			04/08/2	
		1.000.0	B. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ORTH GRANT STREET		
PARKWO	OOD HEALTH CARE	CENTER		LEBAN	ON, IN46052		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
F0279	The facility must descare plan for each measurable object meet a resident's mental and psycholidentified in the color of the care plan must are to be furnished resident's highest mental, and psycholidentified under §44 would otherwise but are not provide exercise of rights of the right to refuse (4). Based on color interview, review, the to develop identifying strategies residents was swallowing the same and the color of the care plan must are to be furnished resident's highest mental, and psycholidenties of rights of the right to refuse (4).	evelop, review and revise the hensive plan of care. evelop a comprehensive resident that includes tives and timetables to medical, nursing, and osocial needs that are imprehensive assessment. It describe the services that do attain or maintain the practicable physical, isosocial well-being as 83.25; and any services that it e required under §483.25 and due to the resident's under §483.10, including treatment under §483.10(b) Observation, and record e facility failed o a care plan g swallowing for 1 of 1	F02	279	The facility requests that this plar correction be considered its credit allegation of compliance. Submission of the response and P of Correction is not a legal admis that a deficiency exists or that this statement of deficiency was corrected and is also not to be construas an admission of interest agains the facility, the administrator, or a employee, agents, or other individuals who draft or may be discussed in the response and Pla Correction. In addition, preparati and submission of the Plan of Correction does not constitute an admission or agreement of any kills to the facility of the truth of any	lan sion s ctly ed t nny	04/25/2011
					and submission of the Plan of Correction does not constitute an		

Facility ID:

	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378		LDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/08/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH GRANT STREET LEBANON, IN46052				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	the monitoring or resident receiving restrictions for 1 with fluid restrict. This deficient processidents reviewed development in the Findings in the During in the second	he sample of 24.			facts alleged or the corrections of conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan Correction prior to the resolution appeal of this matter solely becaut of the requirements under State as Federal law that mandates submission of the Plan of Corrections a condition to partici in the Title 18 and Title 19 prograthes submission of Plan of Corrections within this time frame should in the way be of non-compliance or admission by the facility.	of of use nd pate ams. ction	
	84 was no having an concerns. The record 84 was rev				It is the practice of this facility to ensure the highest quality of care afforded our residents. Consisten with this practice, the following I been done: The corrective action taken for the resident found to have been affect by the deficient practice was: Resident #11's physician has be contacted with an order receive to discontinue fluid restriction. Resident #84's care plan and Classignment sheet were updated with the Speech Therapy recommendations at the time of ISDH survey. The corrective action taken for the	t t t t t t t t t t t t t t t t t t t	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155378	A. BUI B. WIN	ILDING 04/08/2011		
	PROVIDER OR SUPPLIER DOD HEALTH CARE		_ I	STREET A	ADDRESS, CITY, STATE, ZIP CODE ORTH GRANT STREET ON, IN46052	
	included, limited to: of pneumocompulsive severe meretardation. A speech to document, 10/22/10, the follow small bites sips and to degrees at encourage.	the diagnoses onia, obsessive disorder, and ntal n. therapy, dated recommended ring: "take s and small		1001 N	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) resident having the potential to be affected by the same deficient practice is: No other residents currently have fluid restriction orders. All records were audited to ensure therapy recommendations are implemented, as necessary, with care plans and CNA assignment sheets updated accordingly. The measure put into place and systemic change made to ensure the deficient practice does not recur in the Nursing staff have been educated on comprehensive care plans, including but not limited to necessity of fluid intake monitoring and implementation any therapy recommendations. Therapy and licensed nursing staff have been re-educated on providing communication between two departments to ensure proper interventions for all residents are in place. The Clinical Case Manager, ME Coordinator, or designee, will	DATE Pre Pre Pre Pre Pre Pre Pre Pr
	meal liqui				randomly monitor a minimum of care plans weekly for 60 days, to assure that necessary care plans are developed.)
		ng the care d 8/17/10 with			To ensure the deficient practice do not recur, the monitoring system established is:	oes

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	onstruction 00	(X3) DATE SURVEY COMPLETED	
		155378	B. WIN	IG		04/08/2011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ORTH GRANT STREET	
	OOD HEALTH CARE	CENTER		LEBAN	ON, IN46052	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DNS, or designee, will review	DATE
	a revision date of 3/24/11, the care plan				findings weekly and report to P committee monthly for 6 month	
					determine need for continued	15 10
	noted, "(06) monitor			monitoring thereafter.	
	diet tolera	nce and refer			Completion Date: April 25, 201	1
	to Speech	Therapy if				
	indicated.	(07) Resident				
	will be properly					
	positioned in chair for					
	meals and	staff will				
	ensure foc	od items are				
	within res	ident's reach"				
	During ob	servation of				
	Resident #	#84 at supper				
	on 4/6/11	at 5:40 P.M.,				
	the resider	nt was eating				
	mashed po	otatoes and				
	_	nilk when she				
		cough. The				
		face became				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378	(X2) MULT A. BUILDI B. WING		NSTRUCTION 00	(X3) DATE (COMPL) 04/08/2	ETED
NAME OF	PROVIDER OR SUPPLIEI	₹			DDRESS, CITY, STATE, ZIP CODE	•	
PARKW	OOD HEALTH CAR	E CENTER	1001 NORTH GRANT STREET LEBANON, IN46052				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX CAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	very red a	and she					
	coughed 1	for 5 minutes.					
	Two staff	members(one					
	of them w	as LPN #1-the					
	unit mana	ger) came to					
	the table a	and asked if she					
	was all right. Resident						
	shook her	head yes, but					
	continued	to cough. No					
	staff told	the resident to					
	take smal	ler bites or sips					
	or encour	aged her to					
	drink her	fluids.					
	In an inter	rview with					
	CNA #2 c	on 4/7/11 at					
	1:25 P.M.	, the CNA was					
	queried al	oout where					
	instruction	ns would be					
	found for	CNA's for					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/08/2011	
	PROVIDER OR SUPPLIER		P . WII.	STREET A	ADDRESS, CITY, STATE, ZIP CODE ORTH GRANT STREET ON, IN46052		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	special fee	eding					
	technique	s for Resident					
	#84. CNA	A #2 indicated					
	if there wa	as special					
	assistance	needed					
	regarding	feeding for					
	residents it would be						
	found on 1	the CNA					
	assignmer	nt sheet. The					
	CNA revi	ewed the sheet					
	and there	were no					
	recommen	ndations on the					
	sheet. The	e CNA					
	indicated	they encourage					
	the reside	nt to slow					
	down if th	ey notice she					
	is choking	g on food and					
	to slow do	own when					
	drinking.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378			LDING	NSTRUCTION 00	(X3) DATE COMPL	LETED	
	PROVIDER OR SUPPLIER		p. wiiv	1001 NO	ORTH GRANT STREET ON, IN46052		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	In an inter	view					
	immediate	ely following					
	interview	with CNA,					
	LPN #1 w	as asked the					
	location o	f where					
	feeding as	sistance					
	information	on for CNA's is					
	kept. LPN	N # indicated					
	information	on was on the					
	CNA shee	et as well as it					
	should be	identified on					
	the care p	lan. LPN #1					
	indicated	she was not					
	aware Re	sident #84 had					
	any specif	fic strategies					
	for feedin	g. She looked					
	at Speech	Therapy notes					
	and saw tl	nat there was					
	swallowin	g strategies					
	mentioned	l, but there was					

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		155378	A. BUIL B. WING			04/08/2	011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ORTH GRANT STREET		
PARKWO	OOD HEALTH CARE	CENTER			ON, IN46052		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	no outline	d					
	recommer	ndations					
	anywhere	she could find					
	and it was	not on the					
	care plan.	She indicated					
	this was th	ne first she					
	knew that this resident						
	had proble	ems with this.					
	She stated	she was going					
	to talk to s	speech therapy					
	to see wha	at the strategies					
	were and	would update					
	the care p	lan and CNA					
	sheet.						
SS=D		record of Resident #11			The facility requests that this plan correction be considered its credit		04/25/2011
	was reviewed on	4/8/11 at 9:15 A.M.			allegation of compliance.		
	_	esident #11 included, but			Submission of the response and P		
	disease and deme	to, end stage renal entia.			of Correction is not a legal admiss that a deficiency exists or that this	3	
	A Dhyminianta and	for dated 1/12/11			statement of deficiency was correcited and is also not to be constructed.		
	_	der, dated 1/13/11, sident was on fluid			as an admission of interest agains the facility, the administrator, or a		
					, , , , , , , , , , , , , , , , , , , ,		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9TZ611

Facility ID:

000468

If continuation sheet

Page 9 of 71

li '			(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLET			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155378	B. WIN			04/08/2011	
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
DADIGAG	000 11541 711 0405	- 0511755		1	ORTH GRANT STREET		
PARKWO	OOD HEALTH CARE	ECENTER		LEBAN	ON, IN46052		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
		he limit was 1800 cc			employee, agents, or other		
	(cubic centimeter	rs) a day.			individuals who draft or may be discussed in the response and Pla	n of	
					Correction. In addition, preparati		
	An "Individual R	Lesident Meal Intake			and submission of the Plan of		
	Record, dated for	r the month of February,			Correction does not constitute an		
	indicated the total	al amount of the meals			admission or agreement of any ki	nd	
	eaten, it did not i	ndicate the amount of			by the facility of the truth of any		
		the resident during a			facts alleged or the corrections of		
	meal.				conclusions set forth in this allegation by the survey agency.		
					anegation by the survey agency.		
	There was no Pla	nn of Care indicating the			Accordingly, the facility has		
		dietary would give or the			prepared and submitted this Plan	of	
		would offer the Resident			Correction prior to the resolution		
	_	would offer the Resident			appeal of this matter solely becau		
	daily.				of the requirements under State and	nd	
		ta a pro-			Federal law that mandates submission of the Plan of		
	_	iew with the Dietary			Corrections a condition to particip	nate	
	·	/8/11 at 9:50 A.M., she			in the Title 18 and Title 19 progra	· I	
		gives Resident #11: 11			The submission of Plan of Correc		
		st, 4 oz. with lunch and 4			within this time frame should in r	10	
		They don't monitor the			way be of non-compliance or		
	fluids, nursing tra	acks the Resident's fluids.			admission by the facility.		
	During an intervi	iew with RN #12, on			F279		
	4/8/11 at 10:00 A	A.M., she indicated Intake			1.2.7		
	and Output (I&O				It is the practice of this facility to		
		e was no record of			ensure the highest quality of care	is	
	Resident #11's fl	uid intake.			afforded our residents. Consistent		
					with this practice, the following h	as	
	3.1-35(a)(1)				been done:		
					The corrective action taken for th	e	
					resident found to have been affect		
					by the deficient practice was:		
					Resident #11's physician has bee		
					contacted with an order received	i	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	l		00	COMPL	ETED
		155378	A. BUILDIN	NG		04/08/20	011
		.000.0	B. WING			0 00	
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
					ORTH GRANT STREET		
PARKWO	OOD HEALTH CAR	E CENTER		EBAN(ON, IN46052		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	T.	AG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		DATE
					to discontinue fluid restriction.		
					Resident #84's care plan and CN	NA	
					assignment sheet were updated		
					with the Speech Therapy		
					recommendations at the time of		
					ISDH survey.		
					TT1		
					The corrective action taken for the		
					resident having the potential to be	;	
					affected by the same deficient		
					practice is:		
					No other residents currently have fluid restriction orders.	ve	
					finia restriction orders.		
					All records were audited to ensu	ıre	
					therapy recommendations are		
					implemented, as necessary, with	1	
					care plans and CNA assignment		
					sheets updated accordingly.		
					The measure put into place and		
					systemic change made to ensure t	he	
					deficient practice does not recur i	s:	
					Nursing staff have been educate		
					on comprehensive care plans an	a	
					development of care plans,		
					including but not limited to		
					necessity of fluid intake	of	
					monitoring and implementation any therapy recommendations.	VI	
					Therapy and licensed nursing st	off	
					have been re-educated on		
					providing communication between	en	
					the two departments to ensure		
					proper interventions for all		
					residents are in place.		
					The Clinical Case Manager, MD	os	
					Coordinator, or designee, will		
						l	

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155378		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/08/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH GRANT STREET LEBANON, IN46052				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	X (EACH COR) CROSS-REFE	DER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				care plans assure that are develop	he deficient practice d	0	
				findings we committee determine monitoring	esignee, will review eekly and report to Pomonthly for 6 month need for continued g thereafter.	is to	
F0282 SS=E	facility must be proin accordance with plan of care. A. Based on recordance facility failed order for a P.R.N according to a sliresidents reviewed P.R.N. sliding scoof 24 residents recording to a sliresidents recording to a sliresidents recorded according to a sliresidents recorded to the facility failed document the amfor 1 of 1 resident physician's order	ded or arranged by the ovided by qualified persons in each resident's written ord review and interview, to follow a physician's if [as needed] insuling ding scale key, for 1 of 2 and who were receiving a fale insulin; in a sample eviewed. [Resident #59] ord review and interview, to monitor and ounts of fluids consumed at reviewed who had a for a fluid restriction; in sidents reviewed.	F0282	resident for by the defice Resident #3 notified with Contacted value to discontinuation Resident #4 obtained deficit to the deficit to the deficit to the deficit to the deficit the defic	tive action taken for the und to have been affectient practice was: 59's physician was the new orders received with an order received nue fluid restriction. 69 had a TSH level wing the ISDH survey was notified of the laboration.	ed. en d	

	l i			ULTIPLE CO	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155378	B. WIN			04/08/2011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
	OOD HEALTH CARE	CENTED		1	ORTH GRANT STREET	
					ON, IN46052	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
IAG	REGULATORY OR	LSC IDENTIFFING INFORMATION)	+	IAG	Resident #85 had BMP, CBC, li	-
		1 . 1			profile, and TSH obtained and	VCI
		ord review and interview,			physician has been notified of th	ne
		to obtain laboratory tests			lab results.	
		red by the physician for 3				
	l '	a sample of 24 residents			Resident #92's physician is awar	
	reviewed. [Resid	lents #69, #85, and #92]			of the 3/9/2011 CBC result with	no
					new orders obtained.	
	Findings include	:				
					The corrective action taken for the	ose
	A.1. The clinical	l record for Resident #59			residents having the potential to b	oe
	was reviewed on	4/5/11 at 10:17 A.M.			affected by the same deficient	
	Diagnoses includ	led, but were not limited			practice is:	
	to, a C.V.A. [stro				The share start of the share sta	-11
	l '	alysis] and aphasia,			The glucometer flow records of residents have been reviewed with the state of the s	
	seizure disorder,				physician notifications made as	
	insulin-dependen				necessary.	
	msum-dependen	it diabetes.				
	The April 2011 p	hysician order recap			No other residents currently have	ve
					fluid restriction orders.	
		heet listed orders that			A full house audit has been	
	· ·	re not limited to, the			conducted to ensure all ordered	
		11-Lantus insulin, 60			labs have been obtained.	
	1	very evening; and 2/7/11-				
		15 units routinely every			The measures put into place and	.
	morning.				systemic change made to ensure	l l
		cu-check [finger stick			deficient practice does not recur i	S:
		was ordered to be done			Licensed nurses have been	
	twice a day, with	Humulin R insulin to be			re-educated on provision of care	ein
	given P.R.N. acc	ording to a sliding scale.			accordance with the plan of car	
	On 2/7/11, the A	ccu-check order was			including but not limited to	
	changed and was	to be done weekly at			assessment of blood sugars and	
	4:00 P.M.	•			following sliding scales insulin	
					orders, necessity of fluid intake monitoring, and obtaining of	
	The sliding scale	for the P.R.N. insulin,			ordered laboratory tests.	
					A performance improvement to	ol
		s ordered as follows:				ol

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378	ĺ	LDING	ONSTRUCTION 00	(X3) DATE COMPI 04/08/2	LETED
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE ORTH GRANT STREET	•	
PARKW	OOD HEALTH CAR	E CENTER		1	ON, IN46052		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	3	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
	from M.D. within units. The "Diabetic M form was identiff P.M. by L.P.N. and document blood amounts of P.R. notification to the done. The "Diabetic M forms for Resident through 2/28/11 blood sugar test required a P.R. Not no documentation follows: 11/16/10, 6:00 A The resident should be a superior of the sugar test required a P.R. Not not the sugar test required a	ts			has been developed that Unit Managers, or designee, will ut to monitor daily, on scheduled days of work, for 30 days, compliance with blood sugar testing and following sliding s insulin orders. A performance improvement has been developed that Unit Managers, or designee, will ut to monitor daily, on scheduled days of work, for 30 days, compliance with documentatifluid intake, as necessary. A performance improvement has been developed that Unit Managers, or designee, will ut to monitor daily, on scheduled days of work, for 30 days, compliance with obtaining or laboratory tests. To ensure the deficient practice not recur, the monitoring system established is: DNS, or designee, will review findings weekly and report to committee monthly for 6 mon determine need for continued monitoring thereafter. Completion Date: April 25, 2	cale tool ilize tool ilize tool ilize dered does m	
	The resident sho	ould have received 8 units.					
		A.MBlood sugar of 165. ould have received 4 units.					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì	ULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE COMPI	LETED
		155378	B. WIN	G		04/08/2	2011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE ORTH GRANT STREET		
PARKWO	OOD HEALTH CARE	CENTER		LEBAN	ON, IN46052		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION DATE
IAG		.MBlood sugar of 128.	+	IAG	DIA (CLINCT)		DATE
		ald have received 2 units.					
		.MBlood sugar of 203.					
	· ·	ald have received 8 units.					
		.MBlood sugar of 222.					
		ecorded as given, and the					
		re-checked at 7:00 A.M.					
		89. The resident should					
	have received at	least 4 units.					
	12/1/10, 6:00 A.I	MBlood sugar of 137.					
	The resident show	ald have received 2 units.					
	12/3/10, 6:00 A.I	MBlood sugar of 173.					
	The resident show	ald have received 4 units.					
	12/4/10, 6:00 A.I	MBlood sugar of 187.					
	The resident show	ald have received 4 units.					
	12/6/10, 6:00 A.I	MBlood sugar of 119.					
	The resident show	ald have received 2 units.					
	· ·	MBlood sugar of 159.					
		ald have received 4 units.					
	1	MBlood sugar of 181.					
		ald have received 4 units.					
	· ·	.MBlood sugar of 150.					
		ald have received 2 units.					
	Í	.MBlood sugar of 156.					
		ald have received 4 units.					
		.MBlood sugar of 128.					
		ald have received 2 units.					
	· ·	.MThere was no					
		f a blood sugar level.					
	· ·	.MBlood sugar of 138. uld have received 2 units.					
		.MBlood sugar of 257.					
	· ·	ald have received 12					
	units.	uiu iiavo toootyeu 12					
	umis.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2)	MULTIPLE CO			(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	А. В	UILDING	00		COMPL	
		155378	B. W	/ING			04/08/2	U11
NAME OF F	PROVIDER OR SUPPLIER		-	1	DDRESS, CITY, STA			
5.5.0.4				I	ORTH GRANT S	STREET		
PARKWO	OOD HEALTH CARE	E CENTER		LEBANG	ON, IN46052			
(X4) ID		STATEMENT OF DEFICIENCIES		ID		PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENC	VE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DE	TELENCT)		DATE
	· ·	A.MBlood sugar of 196.						
		uld have received 4 units.						
	· ·	.MBlood sugar of 438.						
		uld have received 22						
		ndicating the physician						
		d was checked, but there						
		tation that insulin was						
	administered.	M D1 1 0114						
	1	A.MBlood sugar of 114.						
		uld have received 2 units.						
	· ·	A.MBlood sugar of 120.						
		uld have received 2 units.						
		A.MBlood sugar of 203.						
		uld have received 8 units.						
	· ·	A.MBlood sugar of 205.						
		uld have received 8 units						
	· ·	1Blood sugar of 147.						
		uld have received 2 units.						
	· ·	1Blood sugar of 288.						
		uld have received 12						
	units.							
	· ·	1Blood sugar of 201.						
		uld have received 8 units.						
	· · · · · · · · · · · · · · · · · · ·	MBlood sugar of 255.						
		uld have received 12						
	units.							
	· ·	MBlood sugar of 135.						
		uld have received 2 units.						
		MBlood sugar of 127.						
	The resident shou	uld have received 2 units.						
	· ·	MBlood sugar of 117.						
		uld have received 2 units.						
	1/27/11, 6:00 A.M	MBlood sugar of 209.						
	The resident shou	uld have received 8 units.						
FORM CMS-2	2567(02-99) Previous Versio	ons Obsolete Event ID:	9TZ61	1 Facility I	D: 000468	If continuation sh	eet Pa	ge 16 of 71

9TZ611

Page 16 of 71

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMP 04/08/ 2	LETED
	PROVIDER OR SUPPLIER		D. WIIK	STREET A	DDRESS, CITY, STATE, ZIP CODE DRTH GRANT STREET DN, IN46052		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE	(X5) COMPLETION DATE
	The boxes to doc administered wer entries listed abo	rument the amounts					
	ı ~	1 to be done weekly at 7/11, 6:00 A.M., the					
	blood sugar was	recorded as 113. The ave received 2 units, but nent the amount					
	3:30 P.M. and 4/ Director of Nursi opportunity to pr Monitoring Flow month of March, on 4/8/11 at 4:00	ferences on 4/7/11 at 8/11 at 11:00 A.M., the ing was given the ovide the "Diabetic Sheet" forms for the 2011. At the final exit P.M., the March 2011 rovided for review.					
	Flow Sheet" form current Medication [M.A.R.] binder. 4:00 P.M., docur sugar check lever should have rece	Diabetic Monitoring in was located in the con Administration Record An entry for 4/4/11 at mented the weekly blood I as 127. The resident lived 2 units. The box to count of insulin given was					
		January, February, 2011 were reviewed.					

DENTIFICATION NUMBER: 155378 2	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL			ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY		
NAME OF PROVIDER OR SUPPLIER PARKWOOD HEALTH CARE CENTER (A4)D SUMMARY STATEMENT OF DEFICIENCIES (BACH DEFICIENCY MIST BE PERCEDED BY FULL TAG The orders for the Accu-check and P.R.N. sliding scale insulin were listed, but all boxes for each day of the month had a capital "X" marked. The order for the Accu-check indicated "See Diabetic Monitoring Flow Sheet." During the daily conference on 4/7/11 at 3:00 P.M., the Director of Nursing was given the copies of the "Diabetic Monitoring Flow Sheet" forms, high-lighting the dates that no insulin was recorded. In an interview at that time, she indicated she would have to check to see if the insulin amounts were recorded some other place. She confirmed that the "Diabetic Monitoring Flow Sheet" form was to be used to document all blood sugar levels and amounts of P.R.N. insulin given. The forms were returned on 4/8/11 at 9:00 A.M., with no additional information attached. During the final exit on 4/8/11 at 4:00 P.M., the Director of Rusing indicated she had no additional documentation to provided for review. SS=E B.1. The clinical record of Resident #11 FIRETA DIREASS, CITY, STATE, ZIP CODE 1001 NORTH GRANT STREET 1001 NORTH	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	DING	00 COMPLETED			
NAME OF PROVIDER OR SUPPLIER PARKWOOD HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (LEACH DEFICIENCY MUST BE PERCEDED BY FULL TAG (LACH DEFICI			155378			04/08/2011			
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SUMMARY STATEMENT OF DEPICIENCIES ID PROVIDERS RANGE CORRECTION COMPLETION COMPLETION DATE	PARKWO	OOD HEALTH CAR	F CENTER						
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		D 1 651 11 11 1	1 05 11 111			E202		0.4/0.5/2011	
	55=E					F 282		04/25/2011	
was reviewed on 4/8/11 at 9:15 A.M. The corrective action taken for the		was reviewed on	14/8/11 at 9:15 A.M.			The corrective action taken for th	e		
resident found to have been affected							-		
Diagnoses for Resident #11 included, but by the deficient practice was:		Diagnoses for Re	esident #11 included, but						
were not limited to, end stage renal		were not limited	to, end stage renal			_			
disease and dementia. Resident #59's physician was		disease and dem	entia.			Resident #59's physician was			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9TZ611

Facility ID:

000468

If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	CONSTRUCTION (X3) DAT		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155378	B. WIN			04/08/2	011
					ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF I	PROVIDER OR SUPPLIE	R		1001 N	ORTH GRANT STREET		
	OOD HEALTH CAR	E CENTER			ON, IN46052		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	-	TAG			DATE
					notified with new orders receiv	ea.	
	1	der, dated 1/13/11,			Resident #11's physician has be	een	
		sident was on fluid			contacted with an order receive		
	restrictions and	the limit was 1800 cc			to discontinue fluid restriction.		
	(cubic centimete	ers) a day.					
					Resident #69 had a TSH level		
	A Plan of Care,	dated 10-/28/10 and			obtained during the ISDH surv		
	reviewed on 1/2	5/11, indicated the			Physician was notified of the la result.	ıD	
	following: "Pro	blem: End Stage Renal			1 court		
	_	al for altered fluid			Resident #85 had BMP, CBC,	liver	
		oach: (1) Diet as order.			profile, and TSH obtained and		
		ompliance with diet and			physician has been notified of the		
	1 ` ′	(3) Assess for fluid			lab results.		
		ere was no indication of			Resident #92's physician is awa	ıro	
		Resident was to receive			of the 3/9/2011 CBC result with		
	with meals or m				new orders obtained.		
	with means of m	edications.					
	An "Individual I	Resident Meal Intake			The corrective action taken for t	hose	
	Record, dated for	or the month of February,			residents having the potential to		
		al amount of the meals			affected by the same deficient		
	eaten, it did not	indicate the amount of			practice is:		
	1 '	y the resident during a				e 11	
	meal.	,			The glucometer flow records or residents have been reviewed v		
	111041.				physician notifications made as		
	During an inter-	view with the Dietary			necessary.		
	_	4/8/11 at 9:50 A.M., she					
	· ·	gives Resident #11: 11			No other residents currently ha	ive	
	1	•			fluid restriction orders.		
		st, 4 oz. with lunch and 4			A full house audit has been		
		They don't monitor the			conducted to ensure all ordered	il.	
	I fluids, nursing to	racks the Resident's fluids.			labs have been obtained.	•	
	During an interv	view with RN #12, on			The measures put into place and		
	4/8/11 at 10:00 A	A.M., she indicated Intake			systemic change made to ensure	the	
	and Output (I&C	O) was not being			deficient practice does not recur	is:	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/04/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155378	A. BUILDING	00	COMPLETED 04/08/2011
	PROVIDER OR SUPPLIER		1001 N	ADDRESS, CITY, STATE, ZIP CODE	0 1/05/20 11
PARKWO	OOD HEALTH CARE	CENTER	LEBAN	ION, IN46052	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	•		1	CROSS-REFERENCED TO THE APPROPRIA	re in re, le ool lize ale ool lize n of ool lize ered does
				committee monthly for 6 month determine need for continued	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9TZ611

Facility ID:

000468

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	A. BUILDING COMPLETED				
		155378	B. WIN			04/08/2011		
			p. ,,	STREET ADDRESS, CITY, STATE, ZIP CODE				
NAME OF F	PROVIDER OR SUPPLIER				ORTH GRANT STREET			
PARKWO	OOD HEALTH CARE	CENTER	LEBANON, IN46052					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	·	DATE		
					monitoring thereafter.			
					Completion Date: April 25, 201	1		
SS=E		of Resident #85 was			F282	04/25/20	011	
	reviewed on 4/6/	11 at 1:15 P.M			The corrective action taken for the	ne l		
					resident found to have been affect			
	_	esident #85 included, but			by the deficient practice was:			
		to, hypothyroidism,			D :1 4//502 1 ::			
		hypoglycemia and			Resident #59's physician was notified with new orders receive	2d		
	anemia.				notified with new orders receive			
					Resident #11's physician has be	en		
		sician's orders there was			contacted with an order receive	d		
	•	es in lab draws for the			to discontinue fluid restriction.			
	following orders.	A lab draw order for a			Decident #60 had a TSH land			
	BMP [basic meta	abolic panel], CBC			Resident #69 had a TSH level obtained during the ISDH surve	PV.		
	[complete blood	count], liver profile, and			Physician was notified of the lal	· I		
	TSH [thyroid stir	nulating hormone] every			result.			
	six months due in	n March and September.						
		oratory results in the			Resident #85 had BMP, CBC, li	ver		
	-	ese results were found for			profile, and TSH obtained and			
	March 2011.				physician has been notified of the	ie		
					lab results.			
	In an interview w	with the DON (Director of			Resident #92's physician is awa	re		
		11 at 8:50 A.M., after			of the 3/9/2011 CBC result with	I		
	٠,	· ·			new orders obtained.			
		ation on labs for one						
	-	of any more lab results			Th			
		e indicated she had no			The corrective action taken for the			
	more information	1.			residents having the potential to laffected by the same deficient	Je		
					practice is:			
	C. 2. The record	for Resident #69 was			The glucometer flow records of	all		
	reviewed on 4/6/	11 at 9 A.M.			residents have been reviewed w	I		
					physician notifications made as			

	l i			ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155378	B. WIN	G		04/08/2011
NAME OF	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•
THINE OF	NO VIDER OR SOLVER	•		1001 N	ORTH GRANT STREET	
PARKW	OOD HEALTH CAR	E CENTER		LEBAN	ION, IN46052	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
					necessary.	
	Diagnoses for R	esident #69 included, but			No other residents enguerate ha	
	were not limited	to, hypothyroid, anxiety,			No other residents currently har fluid restriction orders.	ve
	schizophrenia, a	nd head injury.			nuiu restriction or ders.	
	_				A full house audit has been	
	In reviewing phy	vsician's orders there were			conducted to ensure all ordered	
		b draws for the following			labs have been obtained.	
	1	w order, dated 3/11/10, to				
		el and TSH every six			The measures put into place and	
	1 1 1	•			systemic change made to ensure	
		h and September. There			deficient practice does not recur	is:
		lts for a TSH for March			Licensed nurses have been	
	2011 found.				re-educated on provision of care	e in
					accordance with the plan of car	
	In an interview v	with the DON (Director of			including but not limited to	
	Nursing) on 4/6/	11 at 8:50 A.M., after			assessment of blood sugars and	
	I	nation on labs for another			following sliding scales insulin	
	1	of any more lab results			orders, necessity of fluid intake	;
		ne indicated she had no			monitoring, and obtaining of	
	more information				ordered laboratory tests. A performance improvement to	ol
	inore information				has been developed that Unit	
	C 2 The record	for Resident #92 was			Managers, or designee, will utili	ize
					to monitor daily, on scheduled	
	reviewed 4/5/11	at II A.M.			days of work, for 30 days,	
	D				compliance with blood sugar	,
	1 ~	esident #92 included, but			testing and following sliding sca	ile
	were not limited				insulin orders. A performance improvement to	ol
	dementia, hypert	tension, depressive			has been developed that Unit	01
	disorder, osteopo	orosis.			Managers, or designee, will utili	ize
					to monitor daily, on scheduled	
	A current physic	ian's order dated 5/9/09,			days of work, for 30 days,	
	1	o be done every six			compliance with documentation	of
	months on Augu				fluid intake, as necessary.	,
	inominis on rugu	or and i coraary.			A performance improvement to	ol
	A ravious of late	regults indicated the lab			has been developed that Unit	izo.
		results indicated the lab			Managers, or designee, will utili to monitor daily, on scheduled	izc
	had been drawn	3/9/11.			do monitor dany, on scheduled	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155378	B. WINC	·		04/08/2	011
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH GRANT STREET LEBANON, IN46052				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Nursing) on 4/6/2 providing inform resident, request	with the DON (Director of 11 at 8:50 A.M., after ation on labs for one of any more labs was licated she had no more			days of work, for 30 days, compliance with obtaining order laboratory tests. To ensure the deficient practice do not recur, the monitoring system established is: DNS, or designee, will review findings weekly and report to PI committee monthly for 6 months determine need for continued monitoring thereafter. Completion Date: April 25, 201	oes I s to	
F0309 SS=E	must provide the record review, failed to emonitoring movement licensed n	ordance with the seessment and plan of care. observation, riew and the facility	F0:	309	The corrective action taken for the residents found to have been affect by the deficient practice was: Therapy has evaluated Resident #57 with preventative interventions updated. Resident #57's care plan and CNA assignment sheet have been reviewed and updated to reflect current interventions. BM records for Resident #s 6, 30 57, 69, 92, and 126 have been	t	04/25/2011
	those resid	dents at risk for			reviewed. No treatment for constipation was necessary for		

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378	(X2) MI A. BUII B. WIN	LDING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/08/2011	
	PROVIDER OR SUPPLIER			STREET A	ORTH GRANT STREET ON, IN46052		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	constipation	on and failed to			these residents.		
	assess fac	tors in attempt			The corrective action taken for the residents having the potential to be		
	to prevent	non-pressure			affected by the same deficient practice is:		
	ulcers for	1 of 7			Braden scales have been comple	eted	
	residents 1	reviewed for			for all residents in an effort to identify those residents at risk f	or	
	skin break	down This			development of ulcers. Those residents identified at risk have		
	impacted	6 of 24			had care plan reviews conducted to ensure appropriate preventat		
	•	reviewed for			measures are in place. CNA assignment sheets have been		
	constipation	on in a sample			updated accordingly.		
	•	sidents 6, 30,			All residents have the potential be affected by lack of monitorin		
		and 126) and			of bowel movements, thus this p of correction applies to all		
		7) residents			residents.		
	`	for skin ulcers			The measures put into place and systemic change made to ensure	iha	
	in a sampl				deficient practice does not recur i		
	Findings i				Licensed nurse have been re-educated on provision of necessary care and services, including but not limited to ulco prevention and the newly implemented BM protocol.	er	
	1. The cli	nical record of			A performance improvement to	ol	
	Resident #	#126 was			has been developed that Unit Managers, or designee, will utili	ize	
	reviewed	on 4/7/11 at			to monitor daily, on scheduled days of work, for 30 days, compliance with implementation	n of	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378			LDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/08/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH GRANT STREET LEBANON, IN46052				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	12:30 P.M.				measures to prevent ulcers, and monitoring of residents at risk t constipation with treatment implemented, as necessary.	II	
	Diagnoses for Resident #126 included, but were not limited to, chronic renal insufficiency, dementia and congestive heart failure. The Bowel Movement (BM) records, for the months of January and February 2011, indicated Resident #126 did not have a BM for six days,				implemented, as necessary. To ensure the deficient practice of not recur, the monitoring system established is: DNS, or designee, will review findings weekly and report to P committee monthly for 6 month determine need for continued monitoring thereafter. Completion Date: April 25, 201	I as to	
	and eight	st to the 6th days January bruary 4th. cation					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/04/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155378			ULTIPLE CO LDING	NSTRUCTION 00	COMPL	ETED	
		155378	B. WIN		ADDRESS STATE ZIN CODE	04/08/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE ORTH GRANT STREET		
PARKWO	OOD HEALTH CARE	ECENTER		LEBAN	ON, IN46052		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE.	DATE
	Administr	ration Record					
	(MAR), d	ated for the					
		January and					
	February 2	2011, indicated					
	an order, o	dated 12/7/10,					
	for Bisac-	evac 10 mg					
	(milligran	ns) supp-insert					
	one PR (p	er rectum) as					
	needed for	r constipation.					
	The Resid	lent did not					
	receive th	is medication					
	for constip	pation in					
	January of	r February					
	2011.						
	2. The cli	nical record of					
	Resident #	# 30 was					
	reviewed	on 4/6/11 at					
	3:00 P.M.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378		(X2) MU A. BUII B. WIN	LDING	onstruction 00	(X3) DATE COMPI 04/08/2	LETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH GRANT STREET LEBANON, IN46052					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	Diagnoses	s for Resident#						
	30 include	ed, but were						
	not limite	d to,						
	Depressio	n, Diabetes						
	and osteoa	arthritis.						
	A Plan of	Care, dated						
	3/15/11, ii	ndicated the						
	Resident v	was "At risk for						
	constipati	onr/t (related						
	to) occasion	onal						
	constipati	on, pain meds,						
	decreased	mobility."						
	Approach	es included,						
	but were r	not limited to						
	"Monito	or elimination						
	sheet to m	onitor						
	frequency	of BM's"						
	A Physicia	an's order,						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMP 04/08/	LETED	
	PROVIDER OR SUPPLIER			1001 N	DDDRESS, CITY, STATE, ZIP CODE ORTH GRANT STREET ON, IN46052	Į.	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	"Dulcolax (milligran mouth] evas needed constipation. The Bowe (BM) recomments of indicated.	ery three days for					
	the 10th, for the 12th to for six day the 28th.	March 6th to For five days the 16th and ys the 23rd to , dated for the March 2011,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378			IULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL		
		155378	B. WIN			04/08/2	011
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE ORTH GRANT STREET		
PARKWO	OOD HEALTH CARE	CENTER		1	ON, IN46052		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	DATE
	indicated	the Dulcolax					
	Supp 10 mg (milligrams)						
	po [by mouth] every						
	three days	as needed for					
	constipation	on had not					
	been admi	inistrated					
	during the	month of					
	March 20	11.					
	3. The cli	nical record of					
	Resident #	# 6 was					
	reviewed o	on 4/6/11 at					
	1:00 P.M.	011 1/ 0/ 11 00					
	1.001.141.						
	Diagnoses	s for Resident #					
		l,but were not					
	limited to,	arthritis and					
	chronic co	onstipation.					
	A Plan of	Care, dated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378				LDING	NSTRUCTION 00	(X3) DATE COMPI 04/08/2	LETED
NAME OF I	PROVIDER OR SUPPLIE	R	•	1	ADDRESS, CITY, STATE, ZIP CODE ORTH GRANT STREET	•	
PARKWO	OOD HEALTH CAR	E CENTER	LEBANON, IN46052				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	1/10/11, indicated the						
	Resident	was "At risk for					
	constipati	ion/dehydration					
	r/t decrea	se mobility, c/o					
	(complain	nt of)					
	constipati	ion. Goal:					
	Resident	will have BM					
	at minimi	um q (every) 3					
	days" A	approaches					
	included,	but were not					
	limited to	"Monitor for					
	s/s (signs	and symptoms)					
	of constip	oation, notify					
	MD of un	resolved					
	constipati	ion."					
	The Bow	el Movement					
	(BM) record, for the						
	month of	January 2011,					
		Resident # 6					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378		ļ .	LDING	NSTRUCTION 00	(X3) DATE COMP 04/08/	LETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH GRANT STREET LEBANON, IN46052					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE	
	did not ha	ve a BM for						
	seven day	s January 3rd						
	to the 9th	and for five						
	days Janu	ary the 16th to						
	the 20th.							
	The MAR	, dated for the						
	month of	January 2011,						
	indicated	"Senokot two						
	po (by mo	outh) daily for						
	chronic co	onstipation"						
	was not st	arted until						
	January 2	5th.						
	During an	interview with						
	LPN #14,	on 4/6/11 at						
	2:30 P.M.	, indicated the						
	"N" on the	e BM record						
	means no	bowel						
	movemen	t, so she didn't						

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAIN	OF CORRECTION	155378	A. BUII		00	04/08/2	
		100070	B. WIN		DDDEGG CITY CTATE ZID CODE	0 1/00/2	011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ORTH GRANT STREET		
PARKWO	OOD HEALTH CARE	CENTER		1	ON, IN46052		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG	_	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	have a BM	I on those					
	days.						
SS=E	4. In an interview	w during the initial			F309		04/25/2011
	orientation tour o	on 4/4/11 at 10:05 A.M.,					
	L.P.N. #3 indicat	ed Resident #57			The corrective action taken for the residents found to have been affect	-	
	required staff to p	provide all of his daily			by the deficient practice was:	, ica	
	care, used a mech	nanical lift for transfers,					
		n areas of his right lower			Therapy has evaluated Resident		
	leg due to severe	P.V.D. [peripheral			#57 with preventative interventions updated. Resident		
	vascular disease]	, and was receiving			#57's care plan and CNA	ı	
	Hospice services	The resident was not in			assignment sheet have been		
	his room at the ti	me of the tour, but his			reviewed and updated to reflect		
	bed was observed	d to have a speciality			current interventions.		
	low-air loss mattr	ress.			BM records for Resident #s 6, 30).	
					57, 69, 92, and 126 have been	,	
	A. On 4/4/11 at	1:32 P.M., the resident			reviewed. No treatment for		
	was observed in	the unit Dining/Activity			constipation was necessary for		
	room. The reside	ent was observed to be			these residents.		
		ılty "Broda" geri-chair.			The corrective action taken for the	ose	
	_	cushion in the seat of the			residents having the potential to b	e	
	,	standard pillow was			affected by the same deficient		
		lled up into a tight tube			practice is:		
	•	his right knee. The foot			Braden scales have been comple	ted	
		was in an "up" position,			for all residents in an effort to		
	so that the reside	nt's feet were hanging			identify those residents at risk fo	or	
		y support for the weight			development of ulcers. Those		
	of his legs.				residents identified at risk have	,	
					had care plan reviews conducted to ensure appropriate preventat		
		3 A.M., the resident was			measures are in place. CNA		
	_	n the Broda in the			assignment sheets have been		
		room following the			updated accordingly.		
	breakfast meal.	Γhe rolled pillow was			All residents have the potential t	to	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	I DING	00	COMPLETED
		155378	B. WIN			04/08/2011
		1	P. 1111		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	PROVIDER OR SUPPLIEI	₹		1	ORTH GRANT STREET	
PARKW	OOD HEALTH CAR	E CENTER		1	ON, IN46052	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	,	(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	observed under l	his right knee, with both			be affected by lack of monitorin	g
		_			of bowel movements, thus this p	
	legs and feet hanging down without other support.				of correction applies to all	
					residents.	
	0.4/5/111.0					
	1	0 P.M., the resident was			The measures put into place and	d
		Dining/Activity room to be			systemic change made to ensure the deficient practice does not recur in	I
	1 *	r a dressing change by the			deficient practice does not recui i	S.
	1 -	ility nurses. The rolled			Licensed nurse have been	
	pillow was obset	rved positioned under the			re-educated on provision of	
	resident's right k	nee. After the gauze			necessary care and services,	
	dressings were r	emoved during the			including but not limited to ulce	er
	dressing change,	, the resident was			prevention and the newly	
	observed to have	e open areas of the heel,			implemented BM protocol.	
		d calf areas. An open area			A performance improvement to	ol
		ed behind the right knee.			has been developed that Unit	
	Was also observe	ou commune right mice.			Managers, or designee, will utili	ze
	In an intervious	on 4/5/11 at 1:15 P.M.,		1	to monitor daily, on scheduled	
	1				days of work, for 30 days,	
	Hospice Nurse #				compliance with implementation	I
	1 -	pecialty pressure-relief			measures to prevent ulcers, and monitoring of residents at risk f	I
		ied for his heel, but the			constipation with treatment	01
	1 ^	ore open areas because the			implemented, as necessary.	
		ub his legs together. She			- · · · ·	
	1	low was used under his			To ensure the deficient practice d	oes
	knees to keep the	e heels up and for			not recur, the monitoring system	
	1 -	his right knee contracture.			established is:	
	The nurse indica	ted "other things" had			DNS, or designee, will review	
	been tried, and v	vould be documented in			findings weekly and report to P	r
	1	gress notes. Hospice			committee monthly for 6 month	
		ad documentation related			determine need for continued	
	1 ^ ~	the type of foot boot			monitoring thereafter.	
	1	vere no references found				
	1 '	ressure relief positioning			Completion Date: April 25, 201	1
	_	ed for the contracted right				
	1.	tu for the contracted fight				
	knee.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
THEFTERN	or condition	155378	A. BUI B. WIN			04/08/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1001 N	ORTH GRANT STREET		
PARKWO	OOD HEALTH CARE	ECENTER		LEBAN	ON, IN46052		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION DATE
	On 4/6/11 at 3:45	5 P.M., the resident was					
	observed sitting i	in the Broda chair with a					
	rolled pillow und	ler his right knee. The					
	resident's feet, w	hich were hanging down					
		were crossed at the					
	anklewith his le	eft foot over the right.					
	The clinical reco	rd for Resident #57 was					
	reviewed on 4/4/						
		led, but were not limited					
	_	iaAlzheimer's type,					
	urinary retention	with supra-pubic					
	catheter, hyperter	nsion, contractures,					
	fragile skin, and	hypothyroidism. Hospice					
	services were ini	tiated on 12/23/10.					
	A physician's pro	ogress note, dated 2/3/11,					
		r extremity P.V.D. with					
		rea" A progress note					
	dated 3/14/11 inc	licated " Unavoidable					
	skin breakdown,	severe P.V.D"					
	The "Resident W	eekly Skin Check Sheet"					
		the development of the					
	open areas as fol	-					
	op on arous as ron						
	12/29/10"Treat	ment continues to left					
	_	d right heel." [no other					
	information]						
		ddle finger improved.					
		provement. Treatment					
		foot elevator ordered by					
	Hospice."						

I '		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		COMPI	
		155378	B. WIN			<u>- </u>	04/08/2	UII
NAME OF I	PROVIDER OR SUPPLIEF			1	DDRESS, CITY, STATE, ZIP			
					ORTH GRANT STREE	T		
	OOD HEALTH CARI			<u> </u>	ON, IN46052			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO			(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCT)			DATE
		eel continues black,						
	l *	ith purulent drainage						
		redness or pressure areas."						
	_	physician ordered "D/C						
	1	evalon boots. Resident to						
		ots' at all times						
	1 1 2 2	al TherapyP.T.] to do						
		Monday through Friday."						
	ı	heel remains Stage 4-						
		cal Therapy] continues to						
	treat wound."							
		ral lower extremities cool						
	· ·	int PPP [popliteal pedal						
	pulse]." Areas li	sted as Stage 4 were right						
	heel, right outer	heel, right 3rd toe, right						
	inner 2nd toe, rig	ght great toe, left 2nd toe,						
	and left 3rd toe.	A "Physical Therapy						
	Wound Care Mo	nthly Progress Note"						
	dated 1/28/11 inc	dicated " P.T. had						
	re-educated nurs	ing that resident should						
		ti-podus boots due to						
	1	sed skin integrity and						
		ssure and should be						
		lster or pillows under legs						
		' A physician order,						
	_	dicated "Keep foot rest of						
	1	ed closed to allow						
		al lower extremities to						
		or pressure. Support						
		xtremities with pillows or						
		4/11, the physician						
		Γ. to do wound therapy."						
	ordered D/C1.	1. to do would inclupy.						
	On 3/1/11 the ri	ght calf area was added.						
nonic		_					–	
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	9TZ611	Facility I	D: 000468 If co	ontinuation s	heet Pa	ge 35 of 71

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	ETED
		155378	B. WIN			04/08/20	011
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	ORTH GRANT STREET		
PARKWO	OOD HEALTH CARE	ECENTER		LEBAN	ON, IN46052		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)		TAG	DIA (CIENCI)	+	DATE
	[No stage or mea	isurements were					
	indicated]						
	Δ "Weekly Non-	Pressure Skin Condition					
	1	licated a red area of 4 by					
	1 ^	ters], with a 1.6 by 0.5					
	1 -	st observed behind the					
		/11. An entry on the					
	-	d 3/30/11, indicated the					
		ack at 4 by 0.7 cm.					
		ion at 1 of oir one.					
	A Care Plan entr	y, originally dated					
		h a current update of					
		ed the resident's open					
		ere multiple changes					
		ized boots and other					
	treatments, with	standard approaches					
	listed for nutritio	n and skin checks. One					
	approach for "Po	sitioning" indicated					
	"When resident i	s out of bed, change					
	position every 2	hours by toileting,					
	boosting, shifting	g of weight, ambulating,					
	or return to bed f	for rest." There were no					
	approaches that a	nddressed					
	pressure-relievin	g devices for placement					
		or support for the lower					
	legs, to minimize	e additional compromise					
	to the lower extre	emity circulation.					
		record for Resident #57					
		4/4/11 at 1:35 P.M.					
	~	led, but were not limited					
	l '	iaAlzheimer's type,					
	urinary retention	with a supra-pubic					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	COMPI	
ANDILAN	or connection	155378		LDING	00	04/08/2	
		100070	B. WIN			0-7/00/2	V 1 1
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
PΔRK\M <i>C</i>	OOD HEALTH CARE	- CENTER		1	ORTH GRANT STREET ON, IN46052		
				L	ON, IN 40002		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION DATE
1110		tures, hypothyroidism,	+	1710			Ditte
		history of an intestinal					
	abscess.	mstory of an intestman					
	auscess.						
	The April 2011 p	ohysician order recap					
		sheet listed medications					
		he following bowel					
	of Magnesia [a la	dications: 7/12/10Milk					
		y day P.R.N. [as needed];					
		, ,					
		t [a laxative, stimulant]					
		2/21/11Bisacodyl [a					
	-	xative] Suppository					
		lent was also receiving					
		(10), an anticholinergic,					
		agent with potential					
	adverse reactions						
	•	tructive disease of the					
	_	ract, and ileus. On					
	,	Morphine sulfate] was					
		[milligrams] sublingual					
		hours. Potential					
	_	dverse reactions included					
	constipation and	paralytic ileus.					
	TI. 11E1 C1 -	D					
		Record" for January					
		ne resident had a B.M.					
	-	nt] at least 1 time a day					
	_	1/15/11. A "0" [zero]					
		B.M.s for 7 days from					
	-	-10:00 P.M. to 6:00 A.M.					
		23/11["6-2 "6:00 A.M.					
	to 2:00 P.M. shif	t].					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155378	A. BUI	LDING	00	COMPL 04/08/2	
		100076	B. WIN	_		04/06/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ΡΔΡΚΙΛΙΟ	OOD HEALTH CARE	CENTER		1	ORTH GRANT STREET ON, IN46052		
					ON, IN40032		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		1 M.A.R. [Medication		mo	·		DATE
		_					
	Administration Record] indicated the resident had not received any doses of the						
		Magnesia. Nurse's					
		or January had no					
	~	elated to the lack of a					
	B.M. through thi	s period.					
	The February 20	11 "Elow Choot Docard"					
	1	11 "Flow Sheet Record" dent had a B.M. at least					
	l -	1 2/1 through 2/8/11, with					
		on 2/9, 10, and 11, and a					
		on the 2:00 to 10:00					
		2/11. A "0" [zero] was					
		s for 9 days from 2/13/11					
	-	.M. to 6:00 A.M. shift]					
		["2-10"2:00 P.M. to					
	10:00 P.M. shift]						
		1136 A TO 11 11 11 11					
	l -	11 M.A.R. indicated the					
		Milk of Magnesia on					
		".M. with "no results;"					
	and 2/20/11 at 7:						
	documentation o	f results.					
	On 2/21/11	mdon verog giveon 1 41					
		rder was given by the					
	1 ^ *	enokot 3 tabs one time at					
		esults, give Fleets					
		[morning]." The order					
		ema was listed on the					
		en on 2/22/11, as					
	l -	x marked for that date.					
		nk with no initials from a					
	licensed nurse in	dicating the enema had					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378		(X2) MULTIPLE CO A. BUILDING B. WING	00	li i	E SURVEY PLETED 2011	
	PROVIDER OR SUPPLIER		1001 N	ADDRESS, CITY, STATE, ZIP COI ORTH GRANT STREET ION, IN46052	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	been given.					
	Nurse's Progress documentation:	Notes had the following				
	this time. Will co 2/20/11, 5:50 A.N. signs/symptoms 2/20/11, 11:30 A.B.M. noted." 2/20/11, 9:00 P.N. on brief. Had pro Gave scheduled 3/21/11, 5:45 A.M. shift." 2/21/11, 9:30 A.M. Dulcolax [Bisaco 2/21/11, 1:30 P.N. Gave Bisacodyl. sounds all 4 quac 2011 M.A.R. list Bisacodyl Suppo documentation in had been given. 2/21/11, 8:00 P.M. for B.M. Gave 3 results. New ord 2/22/11, 2:10 A.M. times 1."	M"Gave M.O.M. No M"Had smudge of B.M. Ine juice with dinner. Senokot." M"No B.M. noted this M"New order for Indyl] Suppository" M"Had scant B.M. In No results yet. Bowel Idrants." The February Indeed the order for the Institution of the sittory, but there was no Indicating the suppository M"Continue to monitor Indeed the senokot as ordered. No Indicate the series of the series of the series of the suppository M"Continue to monitor Indicate the suppository M"Had moderate B.M. In the daily In t				
	Director of Mulsi	ng indicated the facility				

Facility ID:

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CC	ONSTRUCTION 00	(X3) DATE S COMPL		
THILD TEATLY	or condection	155378	A. BUI			04/08/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0 0 0 . 2	
NAME OF P	PROVIDER OR SUPPLIER				ORTH GRANT STREET		
PARKWO	OOD HEALTH CARE	CENTER		1	ON, IN46052		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	_	formal policy/procedure					
	or protocol relate	ed to bowel management.					
SS=E		Resident #69 was			F309		04/25/2011
	reviewed on 4/6/	11 at 9.A.M.			The corrective action taken for th	e l	
					residents found to have been affe		
	Diagnoses for Re	esident #69 included, but			by the deficient practice was:		
		to, hypothyroid, anxiety,					
	schizophrenia, he	ead injury, and			Therapy has evaluated Resident	t	
	constipation.				#57 with preventative interventions updated. Residen	.	
					#57's care plan and CNA	١	
	A document titled	d " Flow Sheet Record "			assignment sheet have been		
	was reviewed for	the months of January,			reviewed and updated to reflect		
	February and Ma	rch of 2011. For the			current interventions.		
	month of January	where bowel			DM	.	
	movements [BM]	are recorded, the record			BM records for Resident #s 6, 3 57, 69, 92, and 126 have been	υ,	
	indicated the resi	dent did not have a BM			reviewed. No treatment for		
	January 4th throu	igh January 12th. The			constipation was necessary for		
	-	sician's orders to receive			these residents.		
		ace for constipation daily,			The corrective action taken for th		
		eeded] order for Colace if			residents having the potential to b		
	constipated.	-			affected by the same deficient		
					practice is:		
	In reviewing the	MAR[medication					
	•	cord] no PRN of Colace			Braden scales have been comple	eted	
		was no documentation			for all residents in an effort to identify those residents at risk for	_{or}	
	_	Notes regarding BM's.			development of ulcers. Those	01	
					residents identified at risk have		
	The Flow Sheet I	Record for March also			had care plan reviews conducted		
		arch 19th-March 26th she			to ensure appropriate preventat	tive	
		wel movement. The			measures are in place. CNA assignment sheets have been		
		2011 did not indicated			updated accordingly.		
		Colace had been given.					

000468

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155378	B. WIN			04/08/2011
NAME OF I	PROVIDER OR SUPPLIER	u	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	ROVIDER OR SUPPLIER			1001 N	ORTH GRANT STREET	
PARKWO	OOD HEALTH CARE	ECENTER		LEBAN	ON, IN46052	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
					All residents have the potential	
	In an interview w	vith LPN #1 on 4/6/11 at			be affected by lack of monitorin	- 1
	9:10 A.M., she in	ndicated that if a resident			of bowel movements, thus this p of correction applies to all	ian
	did not have a bo	wel movement for three			residents.	
	days, the staff should take action. The LPN indicated prune juice would be given					
					The measures put into place and	
	_	lidn't work they would			systemic change made to ensure t	
	· ·	gnesia [MOM] or			deficient practice does not recur i	s:
	١٠	ne resident has for			Licensed nurse have been	
		n queried how often the			re-educated on provision of	
		•			necessary care and services,	
	nurses review the flow sheets, she stated when they can. When questioned if				including but not limited to ulce	r
		•			prevention and the newly	
	CNA's are to report if resident has not had a BM and she stated in the morning				implemented BM protocol.	
		•			A	.1
		are addressing this issue			A performance improvement to has been developed that Unit	01
	and trying to wor	rk out the kinks.			Managers, or designee, will utili	ze
					to monitor daily, on scheduled	
		Resident #92 was			days of work, for 30 days,	
	reviewed on 4/5/	11 at 11 A.M.			compliance with implementation	n of
					measures to prevent ulcers, and	
	_	esident #92 included, but			monitoring of residents at risk f constipation with treatment	UI
	were not limited	to, brain injury,			implemented, as necessary.	
	dementia, hypert	ension, depressive				
	disorder, osteopo	prosis.			To ensure the deficient practice d	oes
					not recur, the monitoring system	
	A document title	d " Flow Sheet Record "			established is:	
	was reviewed for	the months of January,			DNS, or designee, will review	
		arch of 2011. Resident			findings weekly and report to Pl	
	<u>-</u>	ian's order to receive			committee monthly for 6 month	
	Senekot two tablets daily and an as				determine need for continued	
	needed order for MOM if constipated.			monitoring thereafter.		
	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2				Completion Date: April 25, 201	,
	For the month of January, the record			Completion Date: April 25, 201	1	
	indicated the resident did not have a BM					
					<u> </u>	
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	9TZ611	Facility	ID: 000468 If continuation sl	neet Page 41 of 71

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S	ETED	
		155378	B. WIN	_		04/08/2	UTI
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PARKWO	OOD HEALTH CARE	E CENTER		1	ORTH GRANT STREET ON, IN46052		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)	+	TAG	DLI ICILICI I		DATE
	-	through January 6th, as					
		2th through 15th, and					
	January 18th through January 26th. The MAR for January indicated that the						
	_	received MOM for that					
		nonth of February 2011,					
		not have any BM's					
		ruary 4th through					
		d February 16th through					
		The MAR did not indicate					
	•	ad been given. Nurses					
	notes were review	· ·					
		vas noted regarding BM's.					
	In an interview w	vith LPN #1 on 4/6/11 at					
	9:10 A.M., she ir	ndicated if a resident did					
	not have a bowel	movement for three					
	days, the staff sh	ould take action. The					
	LPN indicated pr	rune juice would be given					
	first, and if that d	lidn't work they would					
	give Milk of Mag	gnesia [MOM] or					
	whatever order th	ne resident has for					
	treatment. When	queried how often the					
	nurses review the	e flow sheets, she stated					
	-	When asked if CNA's are					
	•	ent has not had a BM and					
		morning meeting that					
	-	ng this issue and trying to					
	work out the kinl	KS.					
	2.1.27()						
	3.1-37(a)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155378	A. BUI	LDING	00	04/08/2	
		199978	B. WIN			04/06/2	011
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
PΔRKW <i>C</i>	OOD HEALTH CARE	CENTER		1	ORTH GRANT STREET ON, IN46052		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION DATE
IAG	REGULATORT OR	ESC IDENTIF LING INFORMATION)	+	IAG			DATE
F0314 SS=D	a resident, the factoresident who enterpressure sores do sores unless the indemonstrates that and a resident have receives necessar promote healing, prevent new sores Based on observation record review, the implement interviewent pressure for 1 resident who open area [Resident pressure sore from the residents who had to a Stage II [Resident practice residents reviewed issues, in a sample reviewed. Findings include: 1. In an interviewed orientation tour of L.P.N. #3 indicate "healing" Stage I coccyx. The clinical record	ation, interview and e facility failed to entions and devices to sores from developing, o developed a Stage II ent #75]; or to prevent a m re-developing, for 2 d a healed area develop sidents #4 and #65]. This e impacted 3 of 7 ed for pressure sore le of 24 residents w during the initial on 4/4/10 at 10:05 A.M., ed Resident #65 had a I pressure sore of the	FO	314	F314 The corrective action taken for the residents found to have been affer by the deficient practice was: Resident #65s pressure ulcer has healed. Resident's care plan and CNA assignment sheet have been reviewed and updated, as necessary, to reflect current preventative measures. Resident #4 was placed on a Lovair Loss mattress at the time of ISDH survey. Resident #4s pressure ulcer has healed. Resident's care plan and CNA assignment sheet have been reviewed and updated, as necessary, to reflect current preventative measures. Resident #75s pressure ulcer has healed. Resident's care plan and CNA assignment sheet have been reviewed and updated, as necessary, to reflect current preventative measures.	cted s ad n w	04/25/2011
	reviewed on 4/5/	11 at 2:30 P.M.			preventative measures.		
	Diagnoses includ	led, but were not limited					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155378	B. WIN			04/08/2011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
5451040	000 11541 711 0405	- 051,755		1	ORTH GRANT STREET	
PARKWO	OOD HEALTH CARE	ECENTER		LEBAN	ION, IN46052	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
		ertension, osteoarthritis,			The corrective action taken for the residents having the potential to be	
	· ·	ronic ulcer of the right			affected by the same deficient	
		hospital History and			practice is:	
	Physical, dated 8	/4/10, indicated the			'	
	resident had been living in an assisted				Braden scales have been comple	eted
	living setting, and	d had been treated for a			for all residents in an effort to	
	right ankle diabe	tic pressure sore for			identify those residents at risk f	or
	several weeks.				development of ulcers. Those residents identified at risk have	
					had care plan reviews conducted	
	The "Resident W	eekly Skin Check Sheet"			to ensure appropriate preventat	
	forms indicated the following: 12/31/10"0.3 by 0.3 cm. [centimeter]				measures are in place. CNA	
					assignment sheets have been	
					updated accordingly.	
	· ·	area between buttocks."			The measures put into place and	d
		ntries dated 12/31/10,			systemic change made to ensure a deficient practice does not recur it	
					deficient practice does not recuir	
	identified the are	•			Licensed nurse have been	
	1	0.2 by 0.2 by 0.1 cm.			re-educated on provision of	
	Stage II."				necessary care and services,	
		II healing wellintact			including but not limited to	
	surrounding skin	*			pressure ulcer prevention.	
	· ·	II on coccyx healed."			A performance improvement to	ol
		re wound on bottom open			has been developed that Unit	
	1 ,	egan treatment again."			Managers, or designee, will utili	ze
	1/26/11"Coccy:	x area 0.5 by 0.5 by 0.2"			to monitor daily, on scheduled	
	2/3/11"Improve				days of work, for 30 days,	
	2/8/11"Coccyx	0.3 by 0.5. Much			compliance with implementation measures to prevent pressure	n 01
	improved"				ulcers.	
	2/23/11"Area o	n coccyx healed"			To ensure the deficient practice d	oes
		·			not recur, the monitoring system	
	3/6/11"Area on	coccyx is 3 by 0.5			established is:	
	cm"				DNC on design!!!	
		x 3 by 1.2 cm. Stage II			DNS, or designee, will review findings weekly and report to P.	г
	area deteriorated	•			committee monthly for 6 month	l l
	area ucierroraled	•			1 committee monthly for 6 month	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155378	A. BUI		00	04/08/2011
		100070	B. WIN		A DDDEGG CITY GTATE ZID CODE	04/00/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ORTH GRANT STREET	
PARKWO	OOD HEALTH CARE	CENTER			ON, IN46052	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	, i	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	determine need for continued	DATE
	l	x decub Stage II, 1 by 1			monitoring thereafter.	
	by 0.1 cm.					
	A !!Niumaala Dmaam	aga Notall antmy datad			Completion Date: April 25, 201	1
		ess Note" entry, dated				
		.M., indicated "Area on				
	'	outer ankle healed. re barrier, order received				
		nue] Santyl to coccyx."				
		ide j Santyi to coccyx.				
	A "Nurse's Progr	ess Note" entry, dated				
		M., indicated "Noted				
	small open area to coccyx"					
	Sinuii open urea t	0 cocyn				
	One Care Plan er	ntry, dated 12/31/11,				
		lem of "At risk for				
	_	to altered skin integrity				
		e ulcer." An intervention				
	for a "low air los	s [mattress] on bed,"				
	dated 12/31, was	crossed out. A second				
	Care Plan entry,	dated 12/31/11,				
	addressed a prob	lem of "At risk for skin				
	breakdown" (One of the interventions				
	was listed as "Pro	essure relieving mattress.				
		e Plan, dated 3/29/11,				
	· ·	addressing "Skin/Tissue				
		al Stage II to coccyx."				
		entions listed was:				
	1 '	re relieving mattress to				
	bedlow air loss	bed."				
	On 4/5/11 at 0.40	A.M., the resident was				
		in a wheelchair in the				
	_	coom. There was a				
	Dinnig/Activity	.com. There was a				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	INSTRUCTION 00	(X3) DATE : COMPL		
THETET	or conduction	155378	A. BUII			04/08/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				ORTH GRANT STREET		
	OOD HEALTH CARE			LEBAN	ON, IN46052		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION DATE
IAG	pressure-relieving		-	IAG			DATE
	^	resident's bed was					
	observed to be in a low position, and was a standard facility "pressure-reducing"						
	·	nattress.					
	mattiess.						
	On 4/8/11 at 1:20	P.M., the resident was					
		laying on her right side.					
	· ·	C.N.A. told L.P.N. #11					
	that the resident l	had been turned on her					
	right side since la	aying down after lunch.					
	L.P.N. #11 told th	he resident that she					
	wanted to look at	t the resident's sore area.					
	After pulling the	blankets back, the					
	resident's coccyx	area was observed. The					
	"Duoderm" dress	sing that had been applied					
	earlier had becon	ne detached at two sides					
	and had crumpled	d into a ball at the coccyx					
		nurse removed the					
	dressing, a 4 cm.						
		nall open area was					
		occyx. In an interview at					
	l '	#11 indicated the open					
		0.1 cm." in size. The					
		sident that she would be					
	1	he dressing. At the					
	· ·	.P.N. #11 located the					
		k sheet, and indicated the					
		easured on 4/6/11 at 0.5					
	by 0.3 cm.						
SS=D	2. During the init	tial tour, on 4/4/11 at			F314		04/25/2011
		V # 3 indicated Resident #					
	4 had a history of	f a open area to the			The corrective action taken for th	e	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155378	B. WIN			04/08/2011	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				ORTH GRANT STREET		
DV DK/V/C	OOD HEALTH CARE	CENTED		1	ION, IN46052		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE	
	coccyx but that it	t was healed.			residents found to have been affe	cted	
				by the deficient practice was:			
	The clinical reco	ord of Resident # 4 was			D.::14 #65	_	
	reviewed on 4/6/	11 at 1:00 P M			Resident #65s pressure ulcer ha healed. Resident's care plan ar		
	10,10,100,000,011,1,0,	11 40 1100 1 1212			CNA assignment sheet have bee	I	
	Diagnagas for De	ogidant # 4 in aludad hut			reviewed and updated, as	"	
	"	esident # 4 included, but			necessary, to reflect current		
		to, end stage dementia,			preventative measures.		
	failure to thrive a	and depression.					
					Resident #4 was placed on a Lo	w	
	A Quarterly Min	imum Data Set			Air Loss mattress at the time of		
	'	ed 2/8/11, indicated			ISDH survey. Resident #4s		
	· ·	a stage II pressure ulcer			pressure ulcer has healed.		
		a stage if pressure after			Resident's care plan and CNA		
	to the coccyx.				assignment sheet have been		
					reviewed and updated, as		
	A Plan of Care, of	lated 12/3/10, indicated			necessary, to reflect current		
	"Res (resident) a	t risk for skin			preventative measures.		
	breakdownHx	of healed pressure			Resident #75s pressure ulcer ha		
	ulcer" Approa	ches: included, but were			healed. Resident's care plan ar		
		low bed with low air			CNA assignment sheet have bee		
	l '	re barrier q shiftturn			reviewed and updated, as		
		•			necessary, to reflect current		
	and reposition q	Z nours			preventative measures.		
	1	ring/Pressure Ulcer"			The corrective action taken for the		
	sheet, dated for the	he month of February			residents having the potential to b	pe	
	2011, indicated a	pressure ulcer had been			affected by the same deficient		
	identified on 2/2/	/11 and healed on			practice is:		
		nt #4 had a pressure ulcer			Duadan saslar harra		
	to the coccyx. Th	-			Braden scales have been completed for all residents in an effort to	cieu	
	· ·				identify those residents at risk f	or	
		or was it staged on this			development of ulcers. Those	UI	
	form.				residents identified at risk have		
					had care plan reviews conducted		
	A Physician's ord	der, dated 2/2/11,			to ensure appropriate preventat		
	indicated "Hydro	ocolloid dsg (dressing) to			measures are in place. CNA		
	sacrum - apply e	O \			assignment sheets have been		
	sacrain appry c	, or j = 0 (days).					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155378 04/08/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1001 NORTH GRANT STREET PARKWOOD HEALTH CARE CENTER LEBANON, IN46052 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE updated accordingly. The measures put into place and A Physician's order, dated 2/16/11, systemic change made to ensure the indicated "Continue protective dressing to deficient practice does not recur is: (sic) hx (history) of open areas on coccyx..." Licensed nurse have been re-educated on provision of necessary care and services, A Nursing note, dated 2/28/11 at 1400 including but not limited to (2:00 P.M.), indicated "Noted St (stage) 2 pressure ulcer prevention. open area on coccyx. 1 cm (centimeter) circumference...." This is the area that A performance improvement tool has been developed that Unit healed 2/16/11 and had reopened 12 days Managers, or designee, will utilize later. to monitor daily, on scheduled days of work, for 30 days, A Nursing note, dated 2/28/11 at 9:00 compliance with implementation of measures to prevent pressure A.M., indicated "Daughter aware area ulcers. reopened on coccyx." To ensure the deficient practice does A Plan of Care, dated 1/25/11 and not recur, the monitoring system rewritten 2/28/11,, indicated "Res established is: (resident) at risk for skin breakdown....Hx DNS, or designee, will review of healed pressure ulcer...2/28/11 Stage II findings weekly and report to PI coccyx area." Approaches: included, but committee monthly for 6 months to were not limited to, "Low bed with low determine need for continued air mattress...moisture barrier q shift...turn monitoring thereafter. and reposition q 2 hours...naps between Completion Date: April 25, 2011 meals..." A CNA (Certified Nursing Assistant) assignment sheet, dated 2/28/11, indicated Resident #4 was to be put back to bed after meals. A Nursing note, dated 3/3/11 at 10:30 A.M., indicated "...Resident up only for

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	155378	A. BUI		00	04/08/2	
		100070	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0 1/00/2	
NAME OF I	PROVIDER OR SUPPLIER			1	ORTH GRANT STREET		
PARKWO	OOD HEALTH CARE	E CENTER		1	ON, IN46052		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IIE.	DATE
	meals and is turn	ed and repositioned	Ī				
	every 1 - 2 hours	"					
	A Nursing note, dated 3/21/11 at 11:00						
	A.M., indicated '	'Area to coccyx					
	healed"						
		1 . 10/01/11					
	· ·	lated 3/21/11, indicated					
	"Res (resident) a						
		of healed pressure					
		tage II coccyx area."					
		luded, but were not					
	limited to, "Low	re barrier q shiftturn					
		2 hoursreposition q 2					
		roda chair- off load					
	pressure."	ioda chan- on load					
	pressure.						
ı	A Physician's sur	nmary, dated for the					
	1 *	011, indicated an order,					
	1 ^	r a "low bed with overlay					
	l '	ngs per comfort of					
	l '	is the same mattress					
	overlay the Resid	lent was on when the					
	coccyx opened in	n February and then					
	reopened in Marc	ch.					
	_	iew with LPN # 15, on					
		M., she indicated the					
	· ·	is inflated and lays on					
	1 ^	ent's mattress. The					
		a low air loss mattress					
	_	takes care of getting the					
	mattresses.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155378 04/08/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1001 NORTH GRANT STREET PARKWOOD HEALTH CARE CENTER LEBANON, IN46052 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The care plan, dated 12/15/10 with Braden scales have been completed for all residents in an effort to revision dates of 3/15/11 and 3/25/11, identify those residents at risk for indicated Stage II to R and L[left] buttock. development of ulcers. Those Interventions included the following: "... residents identified at risk have (01) Therapy as ordered (2) Pressure had care plan reviews conducted to ensure appropriate preventative reducing mattress to bed, (03) staff to measures are in place. CNA assist with bed mobility... (05) Skin assignment sheets have been checks per policy (06) Peri care assist updated accordingly. after incontinent episodes (07) (revision The measures put into place and date of 3/8/11 noted here) Tx)[treatment] systemic change made to ensure the deficient practice does not recur is: as ordered PRN [as needed]...(09) Notify MD [medical doctor] of abnormal Licensed nurse have been findings (10) urinal @ [at] bedside (11) re-educated on provision of Assist to use toilet when OOB [out of necessary care and services, including but not limited to bed]..." The care plan indicated the pressure ulcer prevention. resident is at risk for skin breakdown related to decreased physical functioning A performance improvement tool and use of Prednisone. No interventions has been developed that Unit were included to address the skin Managers, or designee, will utilize to monitor daily, on scheduled breakdown on 1/5/11. days of work, for 30 days, compliance with implementation of In reviewing of records provided by the measures to prevent pressure DON on 4/8/11 at 9:30 A.M., it was found ulcers. that there was no documentation of To ensure the deficient practice does notifying the physician regarding the not recur, the monitoring system wound prior to 1/13/11. The physician's established is: order, dated 1/13/11, indicated, "Cleanse R) [right] buttock wounds, apply DNS, or designee, will review findings weekly and report to PI bacitracin & [and] with dry cover drsg committee monthly for 6 months to [dressing] BID [twice a day] & PRN [as determine need for continued needed] X [times] 14 D [days] then monitoring thereafter. re-eval [re-evaluate]. The physician's order, dated 1/28/11, indicated cont to Completion Date: April 25, 2011 cleanse right buttock wound, apply

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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH GRANT STREET LEBANON, IN46052					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE	
mo	bacitracin & cove	er with a dry dressing use skin prep prior to					DITE	
	4/8/11 at 10: 20 A he came to facilit not really remem first got here. He pain and could no month he was he An opportunity v (Director of Nurs A.M. to provide all wound treatm wound orders fro current. Another exit at 4:15 P.M. information was	vas provided to the DON sing) on 4/8/11 at 9:30 all information regarding ents, skin sheets, and m time of admission to opportunity was given at on 4/8/11, no further						
	3.1-40(a)(2)							
F0371	considered satisfa local authorities; a (2) Store, prepare under sanitary cor	distribute and serve food ditions						
SS=F	Based on observa	ntion and interview, the	F0371		F-371		04/25/2011	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED				
AND PLAN	OF CORRECTION	155378	A. BUI	LDING	00	04/08/2011	
		155576	B. WIN			04/00/2011	
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
PARKWO	OOD HEALTH CARE	- CENTER		1	IORTH GRANT STREET ION, IN46052		
					1011, 114-0032		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
		ensure that the refuse		-			
	-	vered to avoid food					
spillage and that the trays of food in the					The corrective action taken for the		
		properly covered to			residents found to have been affe	cted	
	-	food contamination. This			by the deficient practice was:		
		to affect 123 of 124			The trays of food were covered	at	
	-	ng meals from the facility			the time of ISDH survey.		
	kitchen	ig means from the facility					
	Kitchen				The garbage container lid was		
Findings include:					placed on container at the time ISDH survey.	01	
					isbii sui vey.		
					The corrective action taken for th	ose	
In a tour with Dietary Worker #13 at 4:45 P.M., of the walk- in refrigerator there				residents having the potential to b	pe		
		•			affected by the same deficient		
		idding, 2 trays of cookies,			practice is:		
	· ·	ions that were not			This practice has the potential t	0	
	covered.				affect all residents currently		
	T 4	W //12 4.45			residing in the nursing center.		
		etary Worker #13 at 4:45			Therefore, this plan of correction	n	
		container did not have a e was a box and other			applies to all residents.		
	food matter in the				The measures put into place and		
	1000 matter in the	e container.			systemic change made to ensure	the	
	In on interview :	mmadiataly fallowing the			deficient practice does not recur i	s:	
		mmediately following the			Distance staff h		
	, ,	rker #13 was questioned			Dietary staff have been re-educated on facility policy an	.d	
		ound uncovered and she			procedure relative to Kitchen		
		vere typically covered and			Sanitation, including but not		
	inat sne would re	eview this with staff.			limited to ensuring food is		
	2.1.21(1)(2)				properly covered, and garbage		
	3.1-21(i)(3)				containers are covered.		
					A performance improvement to	ol	
					has been developed that Nutriti		
					Service Manager (NSM), or		
					designee, will utilize to monitor		
					cleanliness of food preparation		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/08/2011
	PROVIDER OR SUPPLIER		1001 N	ADDRESS, CITY, STATE, ZIP CODE ORTH GRANT STREET ON, IN46052	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F0514	each resident in a professional stand complete; accurate accessible; and sy. The clinical record information to identhe resident's asseand services provipreadmission screstate; and progress Based on and interval facility faithe current order reca	record review iew, the iled to ensure t physician p ation] sheets	F0514	area and that all food to be store is covered weekly for one month. To ensure the deficient practice d not recur, the monitoring system established is: NSM, or designee, will review findings weekly and report to Pi committee monthly for 6 month determine need for continued monitoring thereafter. Completion Date: April 25, 201 F514 The corrective action taken for the residents found to have been affect by the deficient practice was: The treatment and medication administration records for Resident #57 were corrected at a time of ISDH survey. The order for Digoxin level for Resident #59 was discontinued as	1 04/25/2011 e cted the
	and of tvi			the time of ISDH survey. Please note that resident did not have t	I

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378			LDING	00	(X3) DATE SURVEY COMPLETED 04/08/2011	
	PROVIDER OR SUPPLIER		P	1001 N	ADDRESS, CITY, STATE, ZIP CODE ORTH GRANT STREET ON, IN46052	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	were correct transcribe to reflect of physician deficiency residents if 24 residents accurate residents.	ration Records] ectly d and checked current orders. This v impacted 5 in a sample of ats reviewed for			laboratory test obtained after to medication had been disconting. The medication administration record and the rewrite for Resident #59 were corrected at time of ISDH survey. As is stated on the 2567, Reside #104 received the last dose of Rocephin on 3/24/11. The medication administration record and rewrite for Resident #104 were reviewed and corrected at time of ISDH survey. The laboratory orders for Resi #17 have been reviewed with the physician, clarification orders were obtained to reflect physicials a current wishes for laboratory orders. The gallbladder catheter order	the ent ord t the dent ne
	Findings in the street orientation	nclude: nterview initial n tour on 10:05 A.M.,			Resident #89 had been discontinued. The rewrite for Resident #89 has been corrected. The corrective action taken for the residents having the potential to affected by the same deficient practice is: All residents of the nursing centary have the potential to be affected. Therefore, this plan of corrective applies to all residents currently residing in the center. The rewrites of all residents has been reviewed, with necessary corrections made and/or	ter d. on y

Facility ID:

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155378	B. WIN			04/08/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
PARKWO	OOD HEALTH CARE	E CENTER		1	ORTH GRANT STREET ON, IN46052	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
	Resident #	#57 had			clarifications obtained.	
	multiple o	pen areas of			The measures put into place and systemic change made to ensure t	he
	his right lower leg and foot, and was receiving				deficient practice does not recur i	s:
					Licensed nurses have received re-education relative to	
	Hospice se	ervices.			maintaining clinical records, including but not limited to	
	1				ensuring current physician orde	r
					recaps and MARs/TARs are correctly transcribed and check	od.
	The clinic	al record for			to reflect current physician orde	
	Resident #	#57 was			A performance improvement too	ol
	reviewed	on 4/4/11 at			has been developed that Unit Managers, or designee, will utili	ze
	1:35 P.M.	Diagnoses			to monitor accuracy of physician order recaps and MARs/TARs.	
	included,	but were not			Unit Managers, or designee, will be responsible to check all	'
	limited to,	, senile			resident's recaps and MARs/TA for the months beginning May 1	
	dementia-	-Alzheimer's			2011, and June 1, 2011. Thereafter, Unit Managers, or	
	tvne urina	ary retention			designee, will be responsible to	
					randomly check at least 15 resident's recaps and MARs/TA	
	with supra	•			for an additional 4 months, for t months beginning July 1, 2011	he
	catheter, h	nypertension,			through October 1, 2011.	
	contractur	es, fragile skin,			To ensure the deficient practice do	oes
	hypothyroidism, and				not recur, the monitoring system established is:	
	severe per	ripheral			Unit Manager, or designee, will	
	vascular d	lisease.			review findings monthly and report to PI committee monthly 6 months to determine need for	for

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155378	A. BUII B. WIN			04/08/2011
NAME OF F	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE ORTH GRANT STREET	
PARKWO	OOD HEALTH CARE	E CENTER			ON, IN46052	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	Hospice so	ervices were			continued monitoring thereafter	·.
	initiated o	n 12/23/10.			Completion Date: April 25, 201	1
	A. An order was written					
	on 2/3/11	to "paint				
	Betadine t	to right heel,				
	right great toe, and left					
	toes daily,	, and apply				
	non-adhes	sive dressing."				
	On 3/18/1	1, the				
	physician	added an order				
	to "Apply	Betadine to				
	area behin	nd right knee				
		non-adherent				
		Wrap with				
	Kerlix"	Wind William				
	IXCIIIA					
	The Anril	2011 physician				
	_	1 •				
		p sheet did not				
	include cu	irrent treatment				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPLE	ETED	
		155378	B. WIN	_		04/08/20)11
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ORTH GRANT STREET		
PARKWO	OOD HEALTH CARE	CENTER		1	ON, IN46052		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	orders for	the open areas					
	on the resi	ident's right					
	foot, lowe	r legcalf, and					
	behind knee.						
	B. On 3/8/11, the						
	physician ordered						
	"Roxinal	a morphine					
	sulfate pai	in medication]					
	20 mg./ml	. [milligrams					
	per millili	ter]=Give 15					
	mg. sublir	ngual every 2					
	hours P.R	•					
	needed].	(. [u b					
	necucuj.						
	The Anril	2011 physician					
	•	1 0					
		p and M.A.R.					
	listed the	order as "Give					
	1 mg"						

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ì		INSTRUCTION 00	(X3) DATE : COMPL	
		155378	B. WIN	LDING IG		04/08/2	011
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE ORTH GRANT STREET		
PARKWO	OOD HEALTH CARE	CENTER		1	ON, IN46052		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	During the	e daily					
	conference	e on 4/7/11 at					
	3:30 P.M., the Director						
	of Nursing	g was given the					
	opportunity to submit						
	any documentation or						
	explanation related to the						
	discrepancy in the						
	orders.						
	At the fina	al exit on					
	4/8/11 at 4	4:00 P.M., the					
	Director o	of Nursing					
		she had no					
		formation to					
		elated to the					
	issues that						
	discussed.						
	2. The cli	nical record					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378			LDING	onstruction 00	(X3) DATE SUI COMPLET 04/08/201	ED
OVIDER OR SUPPLIER	: CENTER		1001 N	ORTH GRANT STREET	1	
(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE ((X5) COMPLETION DATE
for Reside	nt #59 was					
reviewed on 4/5/11 at						
10:17 A.N	 Diagnoses 					
included, l	but were not					
limited to,	seizure					
disorder,						
insulin-dependent						
diabetes, C	C.V.A. [stroke]					
with right	hemiparesis					
[paralysis]	and aphasia,					
and histor	y of					
systolic/di	astolic heart					
failure.						
A. The A	pril 2011					
-	•					
sheet, whi	ch was dated					
as checked	d by a licensed					
nurse on 3	/29/11, listed					
	•					
	ovider or supplier Summary ST (EACH DEFICIENCE REGULATORY OR THE for Reside reviewed of 10:17 A.M. included, landled, landled, landled disorder, insulin-deg diabetes, of with right [paralysis] and history systolic/di failure. A. The Apphysician sheet, whith as checked nurse on 3	OVIDER OR SUPPLIER DD HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) for Resident #59 was reviewed on 4/5/11 at 10:17 A.M. Diagnoses included, but were not limited to, seizure disorder, insulin-dependent diabetes, C.V.A. [stroke] with right hemiparesis [paralysis] and aphasia, and history of systolic/diastolic heart	ovider or supplier DD HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) for Resident #59 was reviewed on 4/5/11 at 10:17 A.M. Diagnoses included, but were not limited to, seizure disorder, insulin-dependent diabetes, C.V.A. [stroke] with right hemiparesis [paralysis] and aphasia, and history of systolic/diastolic heart failure. A. The April 2011 physician order recap sheet, which was dated as checked by a licensed nurse on 3/29/11, listed	ovider or supplier OD HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) for Resident #59 was reviewed on 4/5/11 at 10:17 A.M. Diagnoses included, but were not limited to, seizure disorder, insulin-dependent diabetes, C.V.A. [stroke] with right hemiparesis [paralysis] and aphasia, and history of systolic/diastolic heart failure. A. The April 2011 physician order recap sheet, which was dated as checked by a licensed nurse on 3/29/11, listed	ovider or supplier DD HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION) for Resident #59 was reviewed on 4/5/11 at 10:17 A.M. Diagnoses included, but were not limited to, seizure disorder, insulin-dependent diabetes, C.V.A. [stroke] with right hemiparesis [paralysis] and aphasia, and history of systolic/diastolic heart failure. A. The April 2011 physician order recap sheet, which was dated as checked by a licensed nurse on 3/29/11, listed	Ovider or supplier DO HEALTH CARE CENTER DID HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOR Resident #59 was reviewed on 4/5/11 at 10:17 A.M. Diagnoses included, but were not limited to, seizure disorder, insulin-dependent diabetes, C.V.A. [stroke] with right hemiparesis [paralysis] and aphasia, and history of systolic/diastolic heart failure. A. The April 2011 physician order recap sheet, which was dated as checked by a licensed nurse on 3/29/11, listed

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378		(X2) M A. BUII B. WIN	LDING	onstruction 00	(X3) DATE COMPI 04/08/2	LETED	
	PROVIDER OR SUPPLIER		1	1001 N	ORTH GRANT STREET ON, IN46052		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	-Digoxin	level every 6					
	months/November,						
	May." Th	ne resident had					
	been recei	iving Lanoxin					
	[a heart m	edication]					
	which was	s discontinued					
	on 1/6/11.						
	B. On 9/3	3/10, the					
	physician	had given an					
	order for l	Lasix 40 mg.					
	[milligran	ns] daily, and					
	the order	was listed on					
	the March	2011					
	physician	order recap					
	sheet.						
	The April	2011 physician					
	order reca	p sheet did not					
	list the La	six, and there					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378			LDING	NSTRUCTION 00	(X3) DATE COMP 04/08/2	LETED	
	PROVIDER OR SUPPLIER			1001 N	ADDRESS, CITY, STATE, ZIP CODE ORTH GRANT STREET ON, IN46052		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	was no or	der to					
	discontinu	ie the					
	medicatio	n. The Lasix					
	medicatio	n was listed on					
	the April 2	2011 M.A.R.					
	-						
	In an interview on 4/8/11						
	at 11:00 A.M., the						
	Director of	of Nursing					
	indicated	physician order					
	information	on was given to					
	a data ent	ry staff person,					
	who enter	ed the data and					
	printed ou	it the recap					
	sheets, M.	A.R.s and					
	T.A.R.s [7	Γreatment					
	Administr	ration Record].					
	The forms	s were then					
	given to the	ne nurses on					
		to be checked.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPI 04/08/2	LETED	
NAME OF I	PROVIDER OR SUPPLIEF	₹	•		DDRESS, CITY, STATE, ZIP CODE ORTH GRANT STREET	•	
PARKWO	OOD HEALTH CAR	E CENTER	LEBANON, IN46052				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL LLSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	She offere	ed no other					
	information	on related to					
	the errors	on current					
	recap shee	ets and					
	M.A.R.s.						
	3. The cl	inical record					
	for Reside	ent #104 was					
	reviewed	on 4/6/11 at					
	4:40 P.M.	Diagnoses					
	included,	but were not					
	limited to	, senile					
	dementia-	Alzheimer's					
	type, frac	tured left hip,					
	urinary re	tention, and					
	chronic of	bstructive					
	pulmonar	y disease.					
		-					
	The April	2011 physician					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED B. WING 00 04/08/2011		LETED		
NAME OF PROVIDER OR SUPPLIER PARKWOOD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH GRANT STREET LEBANON, IN46052				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	order reca	p sheet, which					
	was dated	as checked by					
	a licensed	nurse on					
	3/25/11, li	sted an order					
	of "Rocep	hin [an					
	antibiotic	medication] 1					
	Gram intramuscular						
	injection every 12						
	hours."						
	In an interview on 4/7/11						
	at 1:35 P.M., L.P.N. #16						
	indicated	the resident					
	was presc	ribed the					
	Rocephin	after he					
	returned f	rom the					
	hospital fo	ollowing his					
	fractured 1	hip. She					
	indicated	•					
	longer rec	eiving the					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION 00	(X3) DATE S COMPL	
155378		A. BUI B. WIN	LDING IG		04/08/2	011	
NAME OF PROVIDER OR SUPPLIER				1	ADDRESS, CITY, STATE, ZIP CODE ORTH GRANT STREET		
PARKWO	OOD HEALTH CARE	CENTER		LEBAN	ON, IN46052		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T-	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		n, and referred					
	to the Mai	rch M.A.R. for					
	additional						
	document	ation. The					
	March M.	A.R. indicated					
	the residen	nt received the					
	Rocephin for 7 days,						
	with a stop date of						
	3/17/11.	The Rocephin					
	was contin	nued for an					
	additional 7 days, with a						
	Stop/End date of						
	3/24/11.	Γhe resident					
	received t	he last 2 doses					
	of the med	dication on					
	3/24/11.						
	<i>2,2 1,</i> 11.						
	During the	e interview on					
	4/7/11 at 1						
	L.P.N. #10						
	L.F.IN. #10	U a18U					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378		A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/08/2011		
NAME OF PROVIDER OR SUPPLIER PARKWOOD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH GRANT STREET				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
		that nursing					
	staff printe	ed the recap					
	sheets and	l M.A.R.s for					
	the next m	nonth, which					
	came to th	ne unit between					
	the 20th a	nd 25th of the					
	current mo	onth. The next					
	month's recap and M.A.R. was reviewed and checked by one nurse, and rechecked by						
	another nu	ırse.					
SS=E		ecord of Resident #17 4/8/11 at 10:15 A.M.			F514		04/25/2011
	Diagnoses includ to, diabetes, depr pressure and bi-p	led, but were not limited ression, high blood			The corrective action taken for the residents found to have been affect by the deficient practice was: The treatment and medication administration records for Resident #57 were corrected at the stime of ISDH surray.	cted	
	(complete blood order for the CBC A Physician's Sur month of April 20	count). No Physician's C was found in the chart. mmary, dated for the 011, indicated Resident # ne following: Every three			The order for Digoxin level for Resident #59 was discontinued a the time of ISDH survey. Please note that resident did not have t laboratory test obtained after the medication had been discontinu	his e	

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If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155378		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/08/2011	
NAME OF PROVIDER OR SUPPLIER PARKWOOD HEALTH CARE CENTER			1001 N	ADDRESS, CITY, STATE, ZIP CODE ORTH GRANT STREET ON, IN46052	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	I -	C, Valporic acid and wo months a digoxin nes and a BMP.		The medication administration record and the rewrite for Resident #59 were corrected at time of ISDH survey.	the
	4/8/11 at 2:00 P.1 17 was to have a HbgA1C every to	e Director of Nursing, on M., indicated Resident #		As is stated on the 2567, Reside #104 received the last dose of Rocephin on 3/24/11. The medication administration reco and rewrite for Resident #104 were reviewed and corrected at time of ISDH survey. The laboratory orders for Resident 7 have been reviewed with the physician, clarification orders were obtained to reflect physicials current wishes for laboratory orders. The gallbladder catheter order Resident #89 had been discontinued. The rewrite for Resident #89 has been corrected affected by the same deficient practice is: All residents of the nursing central to be affected by the same deficient practice is: All residents of the nursing central to be affected applies to all residents currently residing in the center. The rewrites of all residents have been reviewed, with necessary corrections made and/or clarifications obtained.	rd the lent e an' for i. nose be

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/08/2011	
NAME OF PROVIDER OR SUPPLIER PARKWOOD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH GRANT STREET LEBANON, IN46052			
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				The measures put into place and systemic change made to ensure deficient practice does not recur		
				Licensed nurses have received re-education relative to maintaining clinical records, including but not limited to ensuring current physician orderecaps and MARs/TARs are correctly transcribed and check to reflect current physician ord. A performance improvement to has been developed that Unit Managers, or designee, will util to monitor accuracy of physicia order recaps and MARs/TARs. Unit Managers, or designee, will be responsible to check all resident's recaps and MARs/TAfor the months beginning May 2011, and June 1, 2011. Thereafter, Unit Managers, or designee, will be responsible to randomly check at least 15 resident's recaps and MARs/TAfor an additional 4 months, for months beginning July 1, 2011 through October 1, 2011. To ensure the deficient practice of not recur, the monitoring system established is: Unit Manager, or designee, will review findings monthly and report to PI committee monthly 6 months to determine need for continued monitoring thereaftee.	er ded ders. ol dize n ll dRs d, dRs the	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155378 04/08/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1001 NORTH GRANT STREET PARKWOOD HEALTH CARE CENTER LEBANON, IN46052 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Completion Date: April 25, 2011 SS=E 5. Resident # 89 record was reviewed on 04/25/2011 4/7/11 at 9 A M The corrective action taken for the residents found to have been affected Diagnoses included, but were not limited by the deficient practice was: to, small bowel obstruction, Chron's The treatment and medication disease, gastric cancer, and gastroenteritis. administration records for Resident #57 were corrected at the In an interview with LPN #1 on 4/7/11 at time of ISDH survey. 9:05 A.M., LPN # 1 indicated Resident #89 no longer has a gallbladder catheter The order for Digoxin level for Resident #59 was discontinued at and that it was discontinued. the time of ISDH survey. Please note that resident did not have this The clinical record indicated on the laboratory test obtained after the physician rewrites for April 2011 that the medication had been discontinued. The medication administration resident had a gallbladder catheter. There record and the rewrite for was no indication on the rewrite that the Resident #59 were corrected at the gallbladder catheter had been time of ISDH survey. discontinued. As is stated on the 2567, Resident #104 received the last dose of 3.1-50(a)(2)Rocephin on 3/24/11. The medication administration record and rewrite for Resident #104 were reviewed and corrected at the time of ISDH survey. The laboratory orders for Resident #17 have been reviewed with the physician, clarification orders were obtained to reflect physician' s current wishes for laboratory orders. The gallbladder catheter order for Resident #89 had been discontinued. The rewrite for

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PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY DATE	1001 NORTH GRANT STREET				
Resident #89 has been corrected.	(X5) COMPLETION DATE				
The corrective action taken for those residents having the potential to be affected by the same deficient practice is: All residents of the nursing center have the potential to be affected. Therefore, this plan of correction applies to all residents currently residing in the center. The rewrites of all residents have been reviewed, with necessary corrections made and/or clarifications obtained. The measures that to place and systemic change made to ensure the deficient practice does not recur is: Licensed nurses have received re-education relative to maintaining clinical records, including but not limited to ensuring current physician order recaps and MARS/TARs are correctly transcribed and checked to reflect current physician orders. A performance improvement tool has been developed that Unit Managers, or designee, will utilize to monitor accuracy of physician order recaps and MARS/TARs. Unit Managers, or designee, will be responsible to check all resident's recaps and MARS/TARs. Unit Managers, or designee, will be responsible to check all resident's recaps and MARS/TARs for the months beginning May 1, 2011.					

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	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/08/2011			
NAME OF PROVIDER OR SUPPLIER PARKWOOD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH GRANT STREET LEBANON, IN46052				
(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	Thereafter, Unit Managers, or designee, will be responsible to randomly check at least 15 resident's recaps and MARs/Tafor an additional 4 months, for months beginning July 1, 2011 through October 1, 2011. To ensure the deficient practice on to recur, the monitoring system established is: Unit Manager, or designee, will review findings monthly and report to PI committee monthly 6 months to determine need for continued monitoring thereafter	ARs the does y for er.			
	OVIDER OR SUPPLIER DD HEALTH CARE SUMMARY S (EACH DEFICIEN	155378 OVIDER OR SUPPLIER	OVIDER OR SUPPLIER OVIDER OR SUPPLIER ODD HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL A. BUILDING B. WING STREET. 1001 N LEBAN PREFIX	OVIDER OR SUPPLIER OVIDER OR SUPPLIER OUT HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Thereafter, Unit Managers, or designee, will be responsible to randomly check at least 15 resident's recaps and MARs/Tafor an additional 4 months, for months beginning July 1, 2011 through October 1, 2011. To ensure the deficient practice on trecur, the monitoring system established is: Unit Manager, or designee, will			